Cactus Children's Clinic, PC Patient Demographics Date:_____

PATIENT NAME:_____DOB: _____GENDER: M F

Circle One FATHER/GUARDIAN/STEP-FATHER INFORMATION Patient lives with (circle) Y N

Name:_____ DOB:_____ SS #: _____

Address:_____ City_____ State _____ Zip_____

Preferred Phone:_____Cell / Home Employer:_____

Circle One MOTHER/GUARDIAN/STEP-MOTHER INFORMATION Patient lives with (circle) Y N

Name:_____DOB:_____ SS#:_____

Address:_____City_____State_____Zip_____

Preferred Phone:_____Cell / Home Employer:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact:_____Phone:_____

Relationship to Patient:_____

SIBLINGS

Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____

PRIMARY INSURANCE

Insurance Co._____ ID#_____
Address:_____
Policy Holder:_____ SS #: _____DOB:_____
Group Name:_____Group #_____ Effect. Date:_____

SECOND INSURANCE

Insurance Co._____ ID#_____
Address:_____
Policy Holder:_____ SS #_____DOB:_____
Group Name:_____Group #_____ Effect. Date:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Cactus Children's Clinic, P.C. (CCC) and I understand I am financially responsible for non-covered services and agree to the Financial policies of CCC. In the event payment is not made per agreement and this account is given to collections. I promise to pay all reasonable costs of said collections. I also authorize the release of any medical information necessary to process claims unless this authorization is revoked in writing.

_____ _____

Parent or Authorized Patient Representative Signature Date